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PREPAYMENT DENTAL CARE FOR YOU*

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At present there appears to be an increasing interest in some form of prepayment dental care. The greater number of requests appear to be coming from employer-employee welfare funds which are a part of the so-called "fringe benefits" labor has secured through negotiation with management. Not all requests are from such groups, however; there have been discussions with self-employed persons, with white-collar groups, with public employees, with public agencies representing recipients of public assistance, and, in one or two areas, with farm groups. The requests are similar in nature—some form of insurance or a service plan which may be paid periodically by individuals or by a third party in advance of securing needed care.

Before the dental profession or any other group can produce a sound program of prepaid dental care, it is imperative that certain basic questions be resolved. Some of these are:

1. To what extent is dental care truly insurable?
2. Would it be feasible to begin an insurance program or system before all the subscribers have achieved a specified minimum of dental health? In other words, could a program be developed without the accumulated need first being corrected?
3. Assuming that a prepaid program would be feasible, which method of payment should be adopted: dollar indemnification or service benefits? Further, should it be on a full indemnity basis, partial indemnity, or should it have a deductible feature?

Financing Problems Important

It is recognized that dental disease is almost universal in its incidence, with approximately 98 percent of all people suffering dental ills within their life span. Yet there appears to be no insuperable obstacles to the general principle of insurance, providing indicated safeguards to such a program are instituted. At least two rather important financial factors have to be resolved before dental care insurance can become a reality:

1. What program will be instituted to bring the dental health of participants to a stipulated standard? If the latter is to be a part of the program, how will it be financed, recognizing that the insurance principle cannot be applied to accumulated need.
2. Of lesser importance but of significance for the success of prepaid dental health care benefits is the question of whether the plan is to distinguish between complete care and catastrophic dental care bills. If the latter is applied, a clear definition of "catastrophic" must be incorporated, as a given cost may appear well within the reach of some but be a serious handicap to others.

We have discussed the question of applying the principle of insurance to dental care with many experts in the insurance field. There appears to be complete agreement of opinion among them that without a program outside the insurance program which would cause the dental health of all insured persons to be brought to a minimum standard, insurance is not feasible. Statistics are fragmentary and incomplete, but the cost of providing such initial care per person would run between two and five times the total annual maintenance cost under insurance.

Methods of Payment Defined

Assuming that the problem of meeting a minimum standard could be solved and that the principle of insurance could be applied thenceforth, the method of payment to beneficiaries must be determined and some plan incorporated which would require the subscriber to secure what care is re-

WATCH FOR IT

The June 15th issue of *California's Health* will have the annual clearing list postcard attached to it. If you wish to continue receiving *California's Health*, please detach the card, sign it and return it to us by July 15, 1958.

By state law, we are required to circularize and clear the mailing list each year. Persons who do not return a postcard will be dropped from the mailing list.

* Presented at the Rural Health Conference in Bakersfield, January 31, February 1, 1958.

quired at the time it is needed to prevent another condition of accumulated need. Methods of payment to beneficiaries are defined, in general, as:

1. Under a service benefit, the insured person receives the benefits maxima in units of service rather than in dollars.
2. Under indemnity, the insured person receives the benefits maxima in dollars, depending upon policy provisions and limits. (Indemnity does not necessarily connote complete reimbursement of the insured.)

Determining the accumulated need, and deciding on a program to provide the care necessary to bring the dental health of an individual or a group of individuals to a minimum standard in order to be insurable, are the most serious problems with which we are faced. There appears to be only one manner in which this may be determined with any degree of accuracy, and that is to conduct a survey of a sufficiently large sampling of a group to determine what may be expected in the group as a whole. It would be extremely difficult, if not impossible, in view of the lack of statistics, to adopt a program at this time on any other basis.

Dental care programs developed under employer-employee health and welfare funds, such as that of the International Longshoremen's and Warehousemen's Union-Pacific Maritime Association Welfare Plan, have met the problem by establishing a service program for children from birth through age 14. The group realized it did not have sufficient funds to adopt an adult program and decided the best method to follow was to institute a program which would help the children to grow into adulthood with good dental health rather than as dental cripples. Its program calls for rendering all indicated care to eligible children with the exception of orthodontics and what it terms "cosmetic care" or "esthetic dentistry."

ILWU-PMA Program

The ILWU-PMA Welfare Fund dental care program for children operates in three states, California, Oregon and Washington, on a service basis through the nonprofit dental service corporations of the respective states. In Northern California, its open panel service plan is handled through the California Dental Association Service, the nonprofit organization whose formation was sponsored by the California State Dental Association for the sole purpose of providing a legal vehicle through which prepaid dental care programs could be operated. When a plan is operated as is the ILWU-PMA program, the welfare fund pays the cost of everything required, bringing the mouth to an optimum of dental health and maintaining it in that manner. The small administrative cost is added to the total and is paid by the welfare fund in the same manner as care rendered.

One of the major problems of a dental care program is utilization. This was proved in the early 1930's when the United States Department of Agriculture adopted such a program which failed, primarily, through lack of utilization. Even in the medical-surgical-dental hospital programs operated by employer-employee health and welfare funds which, generally, are conducted at no cost to those eligible to receive care, some run as low as 60 percent utilization. While this may cause the unit cost to look low, it does not accomplish the purpose of the program—good health for those eligible for the care.

100 Percent Participation Needed

In order to cause a dental care program on a group basis to work, it is almost necessary to have 100 percent of those eligible under the plan sign up for it. This is necesary if we are to apply the insurance principle of spreading the loss of a few among the many. In this instance we are dealing with a "loss" which will be experienced not by a few, but by approximately 98 percent of practically any group. There is, of course, some variation depending somewhat on economic status, as it may apply to diet and to education.

In order to be successful, any program, other than one that is cost plus, would have to be on a per capitation basis rather than utilization. In other words, in order to provide sufficient spread, the price of the insurance or the service plan would have to be based on the assumption that all would purchase and utilize the plan.

These are some of the difficulties that must be overcome in order to provide a plan of dental prepayment or dental insurance.

The California Dental Association Service is now providing dental care for groups. The ILWU-PMA Welfare Fund mentioned earlier is one. There are others, but only in children's programs and in these there are the exclusions previously mentioned—orthodontics and cosmetic or esthetic care.

There is interest in adult programs and in some form of prepayment on an individual basis. When it may be possible to develop such plans is a question we cannot answer at this time. There is an adult program which has been running in an eastern city about two years. Unfortunately, there are so many exclusions and elections, the number participating is so small, and the period of operation so short, that statistics relative to the plan are too meager and inconclusive to permit installing a true prepayment or insurance program on the basis of that experience.

Rates Vary With Risk

In order to develop any program of insurance, whether to cover medical-surgical and hospital costs or one's loss from fire, the average or overall loss must be predictable while the risk for an individual must be uncertain. Although we do have generalized figures as to overall costs, we have not had sufficient experience to determine an equitable rate for adults or for individuals regardless of age. Under a true insurance plan, of course, rates must vary according to risk, as when you pay different life insurance rates for different age groups. At age 20 you pay a lower rate than someone age 50 who purchases the same policy. The fire risk of wooden homes with wooden shingles is greater than the fire risk of a brick home with a fire-resistent roof. So it is with dental insurance. If people are going to buy it, the rate must be equitable and must vary. In all probability, the dental insurance rate for a younger person is apt to be higher than for the older age groups, particularly when we are in that age bracket where a large percentage wear full dentures.

We must recognize, too, that in most insurance a person must actually suffer a loss before being reimbursed

by insurance. In fire insurance there must be actual destruction or damage to the property before there is reimbursement. We all recognize the difference as it applies to health insurance. In dentistry, examination, diagnostic X-ray and periodic prophylaxis do not require a loss or destruction of property, yet they are services that must be covered and rendered for which there will be a "loss"—a payment. In other words, the insured person would have encountered an expense even though no restorative dentistry would have been required.

To further illustrate some of the problems involved, consider the Northern California floods of December, 1955. Many seemed to think residents of those areas should have protected themselves with flood insurance. Their natural question was, "Why can't we spread the unpredictable risk of flood insurance?"

Insurance companies answered that they could not sell flood insurance to people who needed it because of this rather simple logic: If, in developing your rate, you attempt to spread the risk between the people in the peaks and the people in the valleys, you come up with a rate in the middle. The people on the peaks will not buy it as the rate is too high and not equitable for their risk. The people in the valley will buy it. It will be a good buy for them, but they will be the only people buying it. If they are the only people buying it, the rate will have to be based on the greatest risk. Consequently, it would be so expensive the people in the valley could not afford to buy.

Dental Care Plan Possible

This does not mean that we shall never have a dental insurance plan for adults. On the contrary, those of us in the association's service are confident that we can and will develop a program we can offer for adults, but, at least in the foreseeable future, such programs will have to be limited to groups. Another probability is that all needed service, with some possible exceptions, will have to be available to everyone in the group, and that it will have to be rated on a per capitation basis.

We are endeavoring to develop a program that will stand the test of time when we offer it to those groups who manifest an interest in a dental prepayment plan. Countless man-days have already been devoted to efforts to resolve the problems. We are confident we are approaching the answer, but we cannot predict when an adult group program can or will be undertaken. If some group in California is really interested and would like to provide a means for getting positive answers to some of these questions, it could render a tremendous service by sponsoring a prepaid dental care plan for adults on the basis of what we normally call cost plus. By this is meant the actual cost of care rendered plus the cost of administering it. The California Dental Association Service is willing to administer such a plan for a group on a nonprofit basis: the association has no interest in making money on any dental care program. This service has been set up to give what the name implies—service.

State Board of Health to Consider Nalline Test Regulations

Regulations for the use of the Nalline test to uncover the use of narcotics by persons on probation or parole will be presented to the State Board of Public Health by this department at a public hearing in Berkeley on Friday, June 6.

By recent legislation the State Department of Public Health, in conjunction with the State Bureau of Narcotic Enforcement, is charged with administration of regulations governing the giving of the test.

The action stems from the new law which permits courts and parole and probation agencies to require as a condition of probation or parole, periodic synthetic opiate antinarcotic (Nalline) tests when the subject is a narcotic user or a suspected user.

The proposed regulations authorize a city or county health officer, or a physician appointed by him, to perform the test. Appointment of a physician to conduct the test must have the approval of the Bureau of Narcotic Enforcement. The physician must have knowledge of the problems of drug addiction and have had instruction and experience in giving the test.

The regulations would also provide that the test be given only upon the request of the agency having supervision of those persons to be tested.

Advisory Committee Named

Malcolm H. Merrill, M.D., State Health Director, has appointed an ad hoc advisory committee of procedure for the Nalline test, composed of physicians prominent in the fields of pharmacology, toxicology, drug addiction, administrative medicine, and medical practice. They will work with this department in drafting procedures and recommendations to assist physicians who may be administering the test as programs develop in the State.

Members of the committee are:

Windsor Cutting, M.D., Professor of Phamacology, Stanford University School of Medicine;
Gordon Epperson, D.O., Oakland;
Roy O. Gilbert, M.D., Los Angeles County Health Officer;
Charles H. Hine, M.D., Associate Clinical Professor of Preventive Medicine and Toxicology, University of California School of Medicine;
Matthew N. Hosmer, M.D., San Francisco;
Harris Isbell, M.D., Director, Addiction Research Center, Public Health Service Hospital, Lexington, Kentucky;
John A. Mitchell, M.D., Chief of Medical Services, Department of Corrections, Sacramento;
Edward L. Russell, M.D., Orange County Health Officer;
Ellis D. Sox, M.D., San Francisco City Health Officer;
James G. Terry, M.D., Office of the Sheriff, Santa Rita Rehabilitation Center (Alameda County); and
Jerome T. Fishgold, M.D., San Francisco (alternate for Doctor Cutting).

Sanitarians' Registration Examination Date Set

The next examination for registration as a sanitarian will be held on Wednesday, June 18, 1958, in Los Angeles and in Berkeley.

Applications may be obtained from the Bureau of Sanitary Engineering, California State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

Summary of Food Poisoning Outbreaks in 1957

During 1957 a total of 101 outbreaks of food poisoning involving 1,872 cases were reported to the California State Department of Public Health. Episodes of food poisoning were reported by 17 counties. The number of persons stricken in these outbreaks ranged from two to 200. In one instance three outbreaks involving 317 cases occurred on the same day. Investigation showed that although the persons involved lived in 11 different counties, they had consumed food in only two places and the food served at both functions was supplied by one caterer.

Approximately 35 percent of the outbreaks were traced to restaurants, 23 percent to homes and 9 percent each to clubs and labor camps. The remaining 24 percent included institutions, schools, catering establishments, bakeries and delicatessens.

Poor refrigeration or no refrigeration for extended periods of time was the reason most often given for outbreaks. Other contributing factors mentioned were: low temperatures in steam tables; improper handling of food; for example, food transported in cars from one place to another; and sores or lesions on the hands or face of the food handler.

Staphylococcus was considered the etiologic agent in 44 outbreaks involving 479 cases, salmonella was suspected in 13 outbreaks with 590 cases, shigella in two outbreaks and streptococcus in one. Chemical, fish and mushroom poisoning accounted for eight outbreaks. In 33 outbreaks with 630 cases the etiologic agent was not determined.

Laboratory examination of the suspected foods was done in half of the outbreaks. Patients and food handlers submitted specimens in about one-fourth of the outbreaks. The reason given for the relative lack of laboratory examination of suspected foods is that usually by the time the local health department is notified the food has been discarded. This is especially true if the incubation period is longer than a few hours.

There are about 3,000,000 hard of hearing children in the United States. —*American Hearing Society News-release*

Accidental Poisonings Take Excessive Toll in 1957

Accidental poisonings are nearly always preventable; even so, 35 California children under the age of five died as the result of swallowing poison last year.

In California last year, an estimated 23,340 children under the age of five were victims of accidental poisoning, according to the State Clearinghouse on Poison Control. Approximately 1,460 of these children were hospitalized.

The clearinghouse is located in the California State Department of Public Health.

Current health department research into the causes and prevention of accidental poisoning of young children reflects the growing public concern with home accidents in California. Efforts are being made by health departments toward developing and testing ways to prevent such accidents.

The first controlled study of the causes of childhood poisoning in the United States is underway in Alameda and Contra Costa Counties as a co-operative research project of the two county health departments, the Berkeley City Health Department, the Alameda-Contra Costa County Medical Association, the University of California School of Public Health and this department.

Public health nurses are presently completing home interviews of approximately 800 families, one-half of which recently have had a poisoned child.

The Santa Barbara City Health Department is utilizing its three-year-old accident reporting system to determine the effect of a city-wide program for the prevention of childhood poisoning on the actual frequency of poisoning and other accidents.

The San Jose City Health Department, with financial support from the National Institutes of Health, has begun a five-year study to determine whether families with a recent childhood poisoning have more accidents than other families, and whether family-directed preventive measures can lower the accident rate.

These studies mark the beginning of an epidemiological research approach to the problems of home accidents which holds promise of being as effective in the reduction of injury as similar approaches have been in the reduction of infection during the last 50 years; and in the reduction of childhood blindness from retrolental fibroplasia in the last three years.

Carriers Greatest Single Source Of Typhoid Fever Cases

Last year there were 74 cases of typhoid fever reported to the California State Department of Public Health, as compared to 102 in 1956 and 99 in 1955. The most common source of infection remains the carrier, accounting for 23 of the 29 cases contracted in California. Three were secondary to other cases and three were possibly water or sewage borne infections.

Of the remaining 45 cases 23 were contracted outside of California, mostly in Mexico, while the source of infection in 22 cases could not be determined. It is probable that carriers were responsible for a number of these cases.

During 1957, 13 cases from three counties were traced to a newly discovered carrier working in a restaurant (see October 15, 1957, issue of *California's Health*). Seven other newly discovered carriers were responsible for one case each, as were three previously known carriers.

Since the most common source of infection in typhoid fever cases occurring in California is the typhoid carrier and because they move from one health jurisdiction to another, the California State Department of Public Health has maintained a typhoid carrier registry for the past five years.

The registry recorded 22 new typhoid carriers last year, while 43 were deleted for various reasons. According to the registry, there were 302 typhoid carriers in the State as of December 31, 1957. The registry listed 323 in 1956, 321 in 1955, 325 in 1954, and 314 in 1953.

AS A MATTER OF FACT IT'S A WEAPON

"Resolved that the hatpin which is a source of danger to public health and safety, should not protrude more than one inch, and that the point should be covered with a guard." *California State Board of Health minutes,* July 6, 1912.

Local Health Officers Hold Spring Meeting

The disposal of hospital wastes and the control of radiation hazards were among the health measures considered by the California Conference of Local Health Officers in their spring meeting in Los Angeles this month.

The conference attended by more than 70 local health officers and staff, gave approval to a resolution which provided methods by which hospitals, clinics and nursing homes can dispose of refuse and still comply with local air pollution control regulations. The action will require the department's hospital advisory board to revise its refuse disposal regulations to comply with local air pollution control rules.

Recognizing that probably the largest single source of ionizing radiation, as far as most individuals are concerned, is that coming from medical uses, the conference adopted a resolution that it work through the State Health Department with the General Practice Section and the Radiologic Section of the California Medical Association and with other professional and industrial societies to investigate, identify and recommend means and measures for the control of radiation hazards.

It was pointed out that public health has two roles to play in connection with medical uses of radiation equipment: by working with the medical profession, to assure the public that the proper use of radiation in medicine for diagnostic and therapeutic purposes is essential and should not be curtailed; and to be able to assure the public that equipment used for such medical purposes is such that the public is spared any unnecessary radiation exposure.

In other action the conference approved the statement of policies for health centers for the 1958-1959 state plan and requested this department to initiate a study of the present formula, ratio of personnel to population, for establishing space requirements for local health departments.

A resolution was passed recommending the inclusion of diagnostic and treatment services for convulsive brain disorders in the crippled children's program.

Also under consideration at the meeting were health officer commitments to mental institutions; standards relating to local public health laboratory directors; and health officer qualifications. The latter would require a year of postgraduate training in public health or three years' administrative experience in public health, effective July 1, 1963.

New Publication

The final report of the California Home Safety Project has been received and distributed to selected agencies and individuals. This publication describes in detail the project carried out from September, 1953, to September, 1957, by the California State Department of Public Health with funds provided by the W. J. Kellogg Foundation.

The report reviews the home accident problem in California, summarizes the research studies conducted by the project staff; outlines a program of state and local health department control activities; and sets forth the conclusions drawn from the project. The report emphasizes the epidemiological approach to accident control.

Contained in the 164-page report are extensive compilations of study findings.

A few copies are still available; however, futher distribution will, if necessary, be limited to those with direct responsibility in home safety programs.

Industrial Hygiene Course

June 2-13, 1958, are the dates for the second annual course on "Elements of Industrial Hygiene for Sanitarians" to be offered by this department in co-operation with the U. S. Public Health Service. The course, offered this year primarily for sanitation personnel in Northern California, will repeat material presented last year in Los Angeles.

Lecture sessions are open to all; laboratory sessions and field exercises are limited to 10 selected sanitarians from specific problem areas.

Program notices have been sent to all local health jurisdictions in the northern area. For further information contact the Bureau of Adult Health, State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

NCPHA Meeting Draws Overflow Crowd

Over 700 persons, the largest number to attend a meeting of the Northern California Public Health Association, gathered at the Castlewood Country Club in Alameda County last month for the association's annual meeting. At least 20 of Northern California's 42 counties were represented at the meeting.

Dr. Paul Lemkau, Professor, School of Hygiene and Public Health, Johns Hopkins University, delivered the luncheon address entitled "Mental Hygiene in Public Health."

The program, a marked departure from previous meetings, featured section meetings during the morning and afternoon sessions.

Officers elected at the meeting were: Mrs. Dalrie Lichtensteiger, Executive Director, California Tuberculosis and Health Association, President; James Malcolm, M.D., Health Officer, Alameda County, President-elect; William Simmons, Chief, Prevention of Blindness Project, California State Department of Public Health, Vice President; Ruth Bishop, Supervising Nurse, San Mateo County Health Department, Secretary; and Glen Kent, M.D., Medical Officer, Contra Costa County Health Department, Treasurer.

Safety Award Recipients

Gilbert Rhodes, former chief of this department's Home Safety Project, has received a special safety award for his efforts in determining the causes of children's accidents. The award was presented to him at the Sixth Annual Eastbay Safety Congress.

Certificates were also awarded to Dr. B. Otis Cobb, of Concord, for devising a Contra Costa County Home Safety program; and to Mrs. Fanny P. Warncke, Chief, Bureau of Public Health Nursing, Oakland District, County Health Department, for research for the Green Cross home safety check list.

Geneticists at the University of California have had considerable success in controlling the sex of offspring in animals.—*UC Clip Sheet*, October 1, 1957.

AMA Formulates "Model" Law To Cut Poison Deaths

The American Medical Association's Committee on Toxicology has drawn up a "model" law for the precautionary labeling of hazardous substances in commercial, household, and industrial chemical products. This would require declaration of hazardous ingredients and warning statements on the label and in the literature accompanying the product.

In a significant departure, the proposed law calls for deletion of the word "poison" from labels. Reference standards, based on animal test, provide a more consistent and reliable index of poisonous properties than did the former label, according to the committee, not only because there are variations in existing legal limits for "poison," but also because there is a lack of agreement among scientists on a definition of the term.

The labeling would apply to hazardous substances which are toxic, irritating, sensitizing, corrosive, flammable, explosive, or radioactive under customary or reasonably anticipated conditions of handling or use.

Requirements of the model law are:

1. Labeling of all chemical products containing hazardous substances that are not now regulated.

2. Applications of the same labeling standards to chemicals for domestic use and for export.

3. Prohibition of re-use of food and drug containers bearing their original labels.

4. Identification and warnings of strongly sensitizing chemicals which cause allergic or inflammatory reactions in living tissue on contact.

Inadequate labeling of potentially harmful chemicals, the committee reports, has been a major handicap to a successful attack on the problem of accidental poisoning. Moreover, lack of information about hazardous ingredients may complicate or delay treatment in emergency situations.

Last year, as was reported in the May 15, 1958, issue of *California's Health*, an estimated 23,340 children under the age of five required treatment after ingesting poisons. Thirty-five of these children died.

Recent Addition to Film Library

PATIENT-NURSE RELATIONSHIPS (Records)
15 records and 44-page handbook

A series of 15 records presenting dramatic episodes of interaction between patients and nurses. An explanatory handbook accompanies the records and provides details about the episodes, as well as suggestions on how the audio-teaching technique can be used. The records provide demonstration of different attitudes, reactions, and techniques, while giving the listener a chance to judge what she would have thought and done under the circumstances. Five situations are presented, each with three episodes of nurse-patient relationships.

The reverse side of each record consists of flashbacks of statements made by the nurse and the patients, providing time for students to indicate briefly in writing how they feel about these statements, what their own response would have been, and how they interpret the comments made and the behavior portrayed.

Records are 33⅓ rpm, microgroove. Record player must have needle capable of handling microgroove records. Suitable for student nurses and other professional groups interested in patient relations.

Public Health Positions

Colusa County

Sanitarian: Salary range, $375 to $415. Starting salary dependent on experience and qualifications. Car necessary, 10 cents mileage allowance. Must have or be eligible for registration. Apply A. E. Raitt, M.D., Colusa County Health Department, 85 East Webster Street, Colusa.

San Diego County

Public Health Microbiologist II: Salary range, $417 to $460. Requires valid public health microbiologist's certificate and either six months of training in a public health laboratory or one year's experience in an approved clinical or hospital laboratory. Write Department of Civil Service and Personnel, Room 402, Civic Center, San Diego 1.

San Mateo County

Supervising Public Health Nurse: Salary range, $464 to $581. Requires completion of program of study for preparation of public health nurses approved by National League of Nursing, plus one year of postgraduate study in the nursing field, including courses and field training in supervision; and at least three years' of supervised public health nursing experience. Apply to Miss Martha Adam, Director, Public Health Nursing Service, 225 37th Avenue, San Mateo.

Santa Clara County

Cerebral Palsy Therapist: Salary range, $433 to $527. Requires graduation from a recognized school of physical therapy, registration with National Registry of Certified Physical Therapists, or eligibility for such registration. Apply W. Elwyn Turner, M.D., Director of Public Health, 2220 Moorpark Avenue, San Jose 28.

SPECIAL CENSUS RELEASES

Special Census of California cities, **Series P-28** *Alameda County*: Livermore (1116); *Contra Costa County*: Martinez (1134); *Fresno County*: Fresno (1134); Mendota (1134); Sanger (1134); Selma (1134); *Humboldt County*: Trinidad Town (1134); *Kern County*: Tehachapi (1134); *Los Angeles County*: El Segundo (1106); Hawthorne (1107); Paramount (1111); Baldwin Park (1120); Burbank (1132); *Madera County*: Madera (1102); *Marin County*: Belvedere (1134); Mill Valley (1134); *Orange County*: Huntington Beach (1134); *Riverside County*: Riverside (1133); *San Benito County*: Hollister (1134); *San Bernardino County*: Redlands (1142); *San Diego County*: San Diego (1074); *San Mateo County*: Menlo Park (1099); *Shasta County*: Anderson (1134); *Solano County*: Dixon (1134); Vacaville (1134); *Yolo County*: Davis (1134).

Copies of these releases may be obtained from: Library, Bureau of Foreign and Domestic Commerce, United States Department of Commerce at 419 Customs Building, 555 Battery Street, San Francisco, California, or at Room 450, 1031 South Broadway, Los Angeles, California.

In ordering, specify series and number as shown in parenthesis. These numbers are *not* population figures.

It is estimated that 40 percent of the active tuberculosis cases (250,000) in the United States are not under medical treatment. — *Medical News*, November 11, 1957

REPORTED CASES OF SELECTED NOTIFIABLE DISEASES
California, Month of April, 1958

Diseases	Cases reported this month			Total cases reported to date		
	1958	1957	1956	1958	1957	1956
Amebiasis	132	221	75	562	666	236
Anthrax	--	--	--	--	--	--
Botulism	--	--	--	--	--	--
Brucellosis	3	5	3	11	8	13
Chancroid	8	8	3	31	28	26
Cholera	--	--	--	--	--	--
Coccidioidomycosis	22	38	19	68	76	61
Conjunctivitis, acute infectious of the newborn	1	--	1	9	1	3
Dengue	--	--	--	--	--	--
Diarrhea of the newborn	--	2	--	16	11	2
Diphtheria	1	--	--	3	4	12
Encephalitis, acute	50	59	58	155	147	170
Epilepsy	412	358	312	1,522	1,253	1,226
Food poisoning	36	148	48	308	239	256
Gonococcal infections	1,489	1,525	1,332	5,868	5,547	5,071
Granuloma inguinale	3	1	1	4	3	1
Hepatitis, infectious	229	176	158	732	684	732
Hepatitis, serum	13	12	16	39	39	35
Leprosy	2	2	--	3	8	2
Leptospirosis	--	--	1	2	--	2
Lymphogranuloma venereum	4	3	4	16	11	10
Malaria	--	4	2	2	7	8
Measles	7,895	12,596	6,916	17,422	37,496	15,965
Meningococcal infections	16	24	21	78	79	121
Mumps	2,821	3,193	5,461	9,118	10,008	20,318
Pertussis (whooping cough)	401	163	229	1,201	503	744
Plague	--	--	--	--	--	--
Poliomyelitis						
Total	9	38	96	48	133	442
Paralytic	5	18	72	28	71	307
Nonparalytic	4	20	24	20	62	135
Psittacosis	2	7	3	8	13	12
Q fever	2	8	9	4	12	17
Rabies, animal	31	24	32	64	43	147
Rabies, human	--	1	--	--	1	--
Relapsing fever	--	--	--	--	--	--
Rheumatic fever	13	14	26	58	55	70
Rocky Mountain spotted fever	--	--	1	--	--	1
Salmonellosis	80	159	113	259	333	403
Shigellosis	163	153	119	485	411	586
Smallpox	--	--	--	--	--	--
Streptococcal infections (including scarlet fever)	1,675	1,143	600	5,060	4,262	2,650
Syphilis	638[a]	629	668	2,278[b]	2,101	2,142
Tetanus	2	3	2	10	8	12
Trachoma	--	--	1	1	1	3
Trichinosis	--	--	3	1	--	5
Tuberculosis	677	671	[c]	2,362	2,491	[c]
Tularemia	--	1	--	1	1	1
Typhoid fever	7	5	8	20	17	31
Typhus fever, endemic	--	--	--	1	1	2
Typhus fever, epidemic	--	--	--	--	--	--
Yellow fever	--	--	--	--	--	--

[a] Excludes 946 cases found positive by special serologic survey (Mexican National farm workers at Border Reception Center, El Centro).

[b] Excludes 1,653 cases found positive by special serologic survey (Mexican National farm workers at Border Reception Center, El Centro).

[c] 1956 data not comparable.

Number of VD Cases Rises in Nation, Slight Decline in California

For the second consecutive year, the total number of reported cases of syphilis has risen in the United States. In California there was a slight drop both in the number of cases and in the case rate.

In 1957, 135,542 cases of syphilis were reported in the Nation as compared with 126,219 in 1956 and 122,075 in 1955. During the same periods of time, California recorded 5,220 cases, with a rate of 42.1 per 100,000 population; 6,427 with a rate of 48.8; and 6,802, a rate of 53.5. No rates were given for the national figures.

Just the reverse is true in the number of reported cases of gonorrhea—in the Nation 216,476 cases were reported in 1957, 233,333 in 1956, and 239,787 in 1955; while in California 15,647 cases were reported in 1957, 15,346 in 1956, and 14,697 in 1955. The case rate for gonorrhea in California is declining. It was 115.7 in 1955, 115.5 in 1956, and 113.2 in 1957.

The increase in the reported incidence of venereal disease is not uniform all over the Country—17 states reported an increase, 19 a decrease, and 12 no change in the occurrence of syphilis and gonorrhea.

In reporting on the number of cases of VD among teen-agers, 14 states indicated a rise in the incidence, one a decline, and 29 no change. Four states did not furnish information for this age group.

Detailed information is contained in the fifth annual joint statement, "Today's VD Control Problem," based on a nationwide survey conducted by the American Social Hygiene Association, the Association of State and Territorial Health Officers, and the American Venereal Disease Association.

The joint statement recommends: a federal appropriation for VD control of $5,700,000; a family-focused VD education program; increased research into diagnostic and treatment methods in gonorrhea; enlistment of the private physician as an active participant in the VD control program; and incorporation of "cluster testing" into routine VD control programs.

Count Shows 3,189 Public Health Nurses Employed in State

The annual count of nurses engaged in public health nursing shows that 3,189 nurses were employed in 562 agencies in California as of January 1, 1958. This is an increase of 217 over last year. The greatest increase was among nurses employed by school districts, 180, as compared to an increase of 26 in local health departments and 9 in visiting nurse associations.

Although there are almost 1,000 more nurses employed in the State now than there were five years ago, 3,189 as compared to 2,299, there are still not enough qualified public health nurses to meet the demand. For example, last fall health departments alone reported 126 vacancies in nursing positions. It is estimated that over 700 more public health nurses will be needed each year just to fill established positions in the State.

The following table gives comparative figures for 1958, 1957, and five years ago:

Type of agency	*Number of agencies*			*Number of nurses*		
	1953	*1957*	*1958*	*1953*	*1957*	*1958*
TOTALS	464	561	562	2,299	2,972	3,189
State	1	1	1	16	20	22*
Local	463	560	561	2,283	2,952	3,167
Health departments	54	59	57	1,033	1,200	1,226
Boards of education	381	472	475	1,049	1,539	1,719
Other official	3	--	--	7	--	--
Visiting nurse associations	25	29	29	194	213	222

* Includes one consultant in Medical Health Division, California Disaster Office.

For the first time enough information was available to include all of the nurses known to be employed in public health in the study of qualifications. Since information is provided by local agencies on a voluntary basis, this represents a high level of co-operation. The table below compares this year's educational qualifications with those of 1957 and 1953:

	1953		*1957*		*1958*	
	Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Public health nurses included in survey	2,227	100	2,916	100	3,189	100
Complete university program of study in public health nursing	1,098	49.3	1,498	51.4	1,619	50.8
One or more college degrees	910	40.9	1,516	52.0	1,648	51.7

WHO in a report has stated that the main health trends are a sustained high birth rate, a stationary death rate, and a receding infant mortality rate.—*Scope Weekly*, November 6, 1957.

Film Supplement Available

The 1958 film catalog supplement listing all 16 mm. films, filmstrips and slides which have been added to the film library of this department since publication of the *Health Film Services—1957 Catalog*, is now available. Copies of the supplement may be obtained by writing the Bureau of Health Education, California State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

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